Welcome to Meridian Acupuncture.

As a practitioner of Traditional Oriental Medicine, I offer an integrated approach to health, including acupuncture, health coaching, herbs and nutrition. My goal is to provide the highest quality medical care by combining traditional wisdom with modern methods. I am committed to helping you achieve health and vitality through a program of healing, prevention, and education. I believe the quality of your health determines the quality of your life.

Enclosed are the intake forms for you to fill out. Please complete and bring them to your appointment. The initial intake and treatment will take approximately 75-90 minutes (ASHP initial consultation is 30-40 minutes). I recommend a protein-rich meal within two hours before each treatment and no refined sugar or caffeine due to acupuncture's strong effect on the body.

For your convenience, I accept cash, checks, and credit cards. I am also happy to check if your insurance covers acupuncture.

The information requested below will assist us in treating you safely and effectively. All information provided will be kept confidential unless permission is provided by you or required by law. Your written permission will be required to release any information, such as billing your insurance.

Thank you for choosing Meridian Acupuncture & Wellness Center. I look forward to meeting you.
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Sincerely,

Chantelle DeShazer, L.Ac., M.T.O.M.

2831 Camino Del Rio South, Suite 218 ◆ San Diego, CA 92108
Phone 619-325-0771 ◆ Fax 619-876-5077 ◆ www.meridianacupuncture.net

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS

Acupuncture

For questions, please call ASH at 800.972.4226

Patient Name_____ Birthdate_____ Primary Language_____ Sex M / F
(Last) (First)

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ PCP Phone #_____
(Required) (Required)

Are you under the care of a physician? ☐ **No** ☐ **Yes, for what conditions?**_____

Please describe your current health problem(s)_____

How and When it began_____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy ☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_____

Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or_____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____ _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

- ☐ Alcohol/Drug Dependence
- ☐ Abnormal Menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Breast Lumps
- ☐ Cancer/Tumor
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diarrhea/Constipation
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Attack
- ☐ Heartburn or Indigestion
- ☐ High Blood Pressure
- ☐ Hospitalizations/Surgical Procedures_____
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Palpitation/Arrhythmia
- ☐ Peptic Ulcer
- ☐ Pregnant, # Weeks_____
- ☐ Prostate Problems
- ☐ Weight Gain/Loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tobacco Use - Type_____ Frequency_____/Day
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ **Medications**_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

- ☐ Cancer_____
- ☐ Heart Disease_____
- ☐ Hypertension_____
- ☐ Lupus_____
- ☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ **Date**_____

PAIN ASSESSMENT

Patient Name _____ Date _____

Chief Complaint 1. _____ 2. _____

Is your present problem due to an injury

☐ On the job? ☐ Auto Accident? ☐ Personal Injury? ☐ Other _____

Did your pain begin ☐ Gradually? ☐ Suddenly?

Do you have pain ☐ All the time? ☐ Sometimes?

Is your pain worse when you

☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other _____

Which of the following areas do you have the most pain, discomfort or restriction of motion?

☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back ☐ Mid Back ☐ Low Back

☐ Pelvis ☐ Hips ☐ Legs ☐ Knees ☐ Feet ☐ Other _____

IN AN 8 HOUR DAY RATE THE PERCENTAGE OF YOUR PAIN WHEN YOU:

Sit _____% of the time

Stand _____% of the time

Walk _____% of the time

OCCASIONALLY = 33%

FREQUENTLY = 34-66%

CONTINUOUSLY = 67-100%

WHAT PERCENT OF YOUR TIME ARE YOU:

☐ Housebound? _____%

☐ Chairbound? _____%

☐ Bedfast? _____%

RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE

1 = LEAST PAIN
10 = EXTREME PAIN

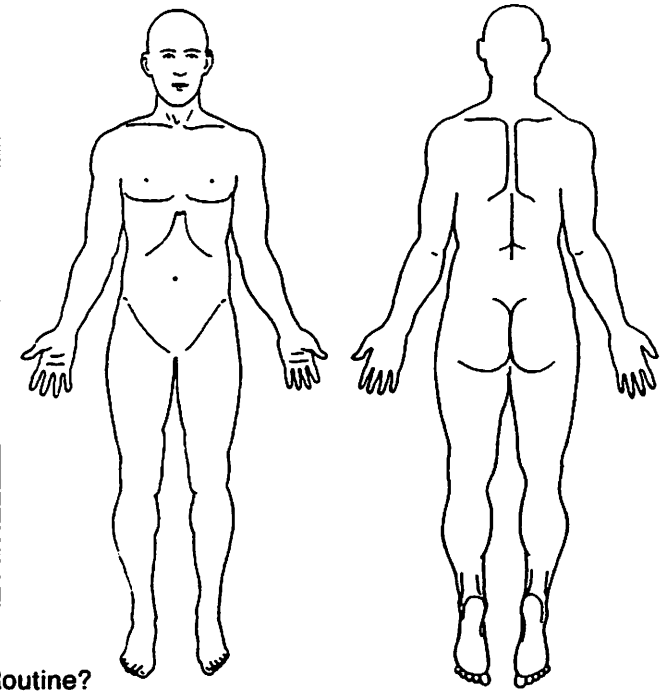
EXTREME

10
9
8
7
6
5
4
3
2
1
0

NO PAIN

MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES

+ + + BURNING
000 STABBING
--- SHARP
||| CONSTANT



Does your pain interfere with your ☐ Work? ☐ Sleep? ☐ Daily Routine?

Do you feel your present condition is ☐ Temporary? ☐ Permanent? ☐ Don't know

List any additional comments you wish to make regarding your condition _____

_____

_____

Patient Signature _____

#2016
MISSION PRINTING (559) 227-7640 • (800) 693-2108

American Specialty Health Plans (ASHP)
P.O. Box 509002, San Diego, CA 92150
888-226-8879 Fax: 619-297-9711

ELIGIBILITY/GUARANTEE ASSIGNMENT OF BENEFITS FORM

CHANTELLE DESHAZER
(name of ASHP acupuncturist)
Meridian Acupuncture
2831 Camino Del Rio South Suite 218
San Diego, CA 92108

Eligibility Guarantee:

I, _____ hereby certify that I am eligible for
(name of patient/Member/guardian)
acupuncture benefits offered by _____ through my
(name of health plan)
employer, _____ as of _____.
(name of employer group) (today's date)

I understand that if the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above Acupuncturist or health plan.

Assignment of Benefits:

I authorize the release of any health information necessary to process this claim. A photo copy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the Acupuncturist listed above who accepts assignment through his/her contact with ASHP and/or ASHP's Health Plans.

I understand that the ASHP Acupuncturist will not bill me for any charges over and above the insurance payment, other than the applicable copayments, coinsurance or deductibles, since the ASHP Acupuncturist has agreed in his/her contact with ASHP and/or ASHP's Health Plans to waive all un-paid fees.

_____ _____
(date) (signature of Member (or subscriber)

Note to Acupuncturist's Office Personnel:
Please keep the original copy of the completed Eligibility Guarantee/Assignment of Benefits Form in the patient's file. If you need to submit this form to ASHP, please send it to ASHP at the address above, If you have any questions, call ASHP ProviderServices at 888/226-8879.

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

MEMBER BILLING ACKNOWLEDGMENT

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____, a member being treated by Chantelle DeShazer, L.Ac.,
(Name of Patient/Member/Subscriber) (Practitioner Name)
do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
effective 1/1/2015	Myofascial release, massage therapy of all types	$7.00
effective 1/1/2015	Cupping or Moxa	$10.00
effective 1/1/2015	Nutritional Therapy, Health Goal Counseling	$37.50/15 min.
effective 1/1/2015	Neuromuscular Re-education	$10.00
effective 1/1/2015	Exercise Therapy	$10.00

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Practitioner may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Practitioner may not bill the member for the difference between what the ASH Contracted Practitioner bills and what the ASH Contracted Practitioner agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Practitioner agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the member. This agreement may only be used to allow the member to agree to "self pay" for specific services <u>in advance</u>.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my practitioner, Chantelle DeShazer, L.Ac., to pay for these services myself.
(Practitioner Name)

Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

_____ Member Signature
(Guardian must sign for all members 17 years or younger)

_____ Member Health Plan ID#

_____ Practitioner Signature

_____ Date

American Specialty Health Plans of California, Inc. {ASH Plans}
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 871/248-2146

INFORMED CONSENT & DISCLOSURE

For questions, please call ASH Plans at 888/226-8879

INFORMED CONSENT:

Acupuncture Provider: CHANTELLE DESHAZER L.Ac.

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgment during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.
The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc, which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- Indirect Moxibustion requires burning an herbal material near the skin of an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow direct moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due tc the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument there is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses micro current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt
- **Treatment Using Control Points Ren 1/Du1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: pregnancy related nausea, pain associated with Multiple Sclerosis, neuro musculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child's medical doctor if/when necessary.

Patient Name: _____ Patient ID # _____

PCP: _____ Patient Signature: _____

PCP Telephone: _____ Date: _____

Meridian
ACUPUNCTURE

NOTICE OF HEALTH INFORMATION PRACTICES

This office creates detailed records of the care and services you receive. We at Meridian Acupuncture are committed to maintaining the privacy of your protected health information. We do not sell or share your information. Information is used for billing purposes.

The Federal Government and the State of California have passed legislation requiring health plans, healthcare clearinghouses, and healthcare providers furnish the individuals with a notice as to how their health information may be used and disclosed to third parties. This notice also details your rights regarding your protected health information. Please read the notice carefully. Copies are available at the front desk.

Chantelle DeShazer is the privacy officer for this office. She will be happy to answer any questions you have regarding how your health information is handled in this office.

Please sign below and return to the front desk:

I have ( ) read and ( ) received a copy of the Meridian Acupuncture Privacy Practices.

Date: _____ Signature: _____

Print Name: _____

2831 Camino Del Rio South, Suite 218 ◆ San Diego, CA 92108
Phone 619-325-0771 ◆ Fax 619-876-5077
www.meridianacupuncture.net

Meridian
ACUPUNCTURE

Cancellation Policy

The time we schedule for you is reserved for you. We often have a waitlist of patients needing to get in for treatment and, without 24 hours notice, we may not be able to get them in.

We realize things happen in life and cancelling an appointment at the last minute may happen no matter how well you've planned your day. As such, we give everyone a 'free-pass' on their first late cancelled appointment. After that, we charge a late cancel fee of $45. You can choose to leave a credit card on file and we can automatically charge your card, or we can email an invoice which you can pay online.

If you choose to leave your credit card on file, then by initialing here you are authorizing us to charge your card in the event you have a late cancellation.

X _____

Initials

_____ Date: _____

Signature of Acknowledgement

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